REVIEW OF THE LITERATURE TO SUPPORT

THE EFFECTIVE PRACTITIONER INITIATIVE

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EXECUTIVE SUMMARY

1. Purpose of Review
This literature review was commissioned by NHS Education for Scotland (NES) in October 2009 to inform the Effective Practitioner Initiative. Effective Practitioner is a new initiative in the early stages of development and is an action within CURAM: the Scottish Government NMAHP Work Programme for Scotland 2009-2011 (SGHD 2009). The aim is to support the continuing professional development of nurses, midwives and allied health professions (NMAHP) at Level 5 and 6 on the Career Framework for Health in Scotland (SGHD 2009a). It will enable clinical staff to progress their skills in a range of key dimensions, including patient experience, patient safety, effective team working and practice development. It complements the wide range of work already in progress which supports NMAHP’s throughout their careers from Flying Start NHS through to advanced and consultant practice. It also supports practitioners to meet KSF and revalidation processes.

2. Introduction
This focused review of the literature was commissioned to explore the perceived Continuing Professional Development (CPD) needs of nurses, midwives and allied health professionals at levels 5 and 6 of the National Career Framework. It includes establishing possible areas of commonality and divergence in perceived education, training and workforce development needs across the professions, as well as a range of significant associated issues, which contribute to the understanding of CPD.

The review was informed by published studies and articles, web based information for example from Health Board and Higher Education websites, and survey data from Governments and relevant professional bodies. The scope of the review was to include clarification of these needs as perceived by both the practitioners and by their managers/employers, and to reflect current health and education policy, in the context of service change and existing and future role development, primarily though not exclusively in the United Kingdom.

The review reflects the common themes in relation to both learning content and methodology, as well as the factors which appear to facilitate or constrain the
implementation of learning into clinical practice.

The main findings are presented under the following themes

- Themes from the literature in relation to
  - Learning needs
  - Learning methods
  - Potential barriers to accessing and implementing the learning from CPD
- Discussion and conclusion

Criteria for inclusion in the review were that the main content was specific to continuing education, included a form of evaluation, and/or was specific to the effectiveness or impact of continuing education in healthcare professions. A total of 83 articles met the selection criteria and have been cited in the review. It is also important to emphasise the limitations; the overwhelming majority of published studies are small in scale, and evaluation tends to be at an individual teaching/learning programme level, and based on the self-assessment and perceptions of the practitioners undertaking them. There is a notable lack of involvement of other stakeholders, including patients and the public, both in relation to learning needs and their perceptions of change and/or improvement. Furthermore, the studies focus on those undertaking CPD; it is more difficult to access the views of those who do not actively engage in CPD, or who define CPD as a particularly narrow group of formal education activities.

3. Effectiveness and Purpose of CPD

The literature on the effectiveness of CPD reflects the range of definitions of the term ‘effective’, with most taking the perspective of the practitioners on the effectiveness of their learning in respect of new skills, improved competence and/or understanding of conditions. Interestingly, from a small sample of University websites, the development of clinical knowledge and skill is a relatively small aspect of ‘Effective Practitioner’ programmes, the focus being on other factors which impact on effective practice, such as, reflection, change management, clinical governance, clinical effectiveness and role theory (University of Bedfordshire 2009; University Campus Suffolk 2009). The literature about the content of CPD programmes across the healthcare professions reflects the need for learning and development in each of the four pillars of practice as defined within
advance professional practice. These are: clinical practice, leadership and management, evidence in practice, learning teaching and supervision (SGHD 2008a). Working effectively in teams is also a commonly cited learning need (Fletcher 2008).

The literature also includes issues in relation to understanding of the purpose of CPD, with a consensus that it is a career-long range of educational/development activities, but the outcomes carry varying emphases around keeping up-to-date, enhancing practice, meeting patient needs and satisfying professional regulatory requirements. More recent literature adds public safety and in its broader context a wider and more direct accountability to patients and the wider public. (Fleet et al. 2008; Fletcher 2008; SGHD 2007). This concept of ‘social accountability’ (Fleet et al 2008) is articulated in a wide range of learning needs identified across the professions, particularly in the need to find better ways of working in partnership with patients, and collaborating with a range of agencies beyond health and social care.

4. Themes from the literature

4.1. Learning Needs

Perhaps it is not surprising that the profession specific literature has many common themes, and describes the same issues around:

- Maintaining and updating clinical skill and knowledge (Bolton 2002; Gill 2007; Doyle et al. 2008; French 2006; King 2009; Freeth et al. 2009; NES 2007; Ireland et al. 2007)
- Challenges around accessing and understanding the evidence base for effective practice given information overload at work and issues of access to on-line material (Bourne et al 2007; Griscti & Jacono 2006; Schoo et al. 2008; Ireland et al. 2007)
- Managing change and surviving (DoH (E) 2006; DoH (E) 2008; NES 2007; Mann et al. 2009; Simpson 2009)
- Professional relationships within and across professions, teams, organisations and agencies (Fleet et al. 2008; Simpson 2009; Wilcock et al. 2009; Barr 2009; Robertson & Bandali 2008)
But there are also other common factors, not least of which is the crucial importance all place on their relationships with patients and clients (Fleet et al. 2008; NES 2009c; SGHD 2008c) and the new and different forms of accountability and trust professionals need to sustain at a time when this has to be earned rather than being automatic, and when public confidence in the NHS and its workforce can sometimes be portrayed as being very low (Calnan and Rowe 2009). Much of the contemporary literature reflects a focus on emotional and interpersonal learning. Calnan and Rowe, (2009) note that trust is still important for effective therapeutic relationships, and is earned via the experience of care, the quality of patient-practitioner interaction, and the compassion and empathy displayed (p102). They posit that trust is in fact a quality indicator.

More detailed elements which practitioners believe they need in relation to CPD, also demonstrate consistency from the recent surveys carried out by governments professional organisations and the literature:

- Research/Evidence based practice (NES 2007; NES 2009a/b; Cusick and McCluskey 2000; Matter 2006)
- Clinical assessment, clinical decision making, and team working (SGHD 2006; French 2006; Bourne et al. 2007; Kenwood and Styles 2009)
- Audit / clinical effectiveness (Lawton et al. 2009; Wainwright and Canning 2008; Bramley 2006)
- Skills to support service redesign/workforce planning; conflict management, (NES 2009c; DoH(E) 2008)
- Advanced communication skills e.g. negotiation and influencing skills, partnership working, motivational interviewing (NES 2009c; Fleet et al. 2008)
- Leadership, management, caseload management; skills to support self-management (NES 2009c; Fleet et al. 2008; Lannon 2007; Porter et al. 2006)
- Health Improvement/Health Promotion Skills (SHHD 2006)
- Political Awareness (NES 2007)

The literature also reflects a consensus on the effectiveness and efficiency of using validated training needs analyses at a local level to establish the specific learning needs within a service and tailor the education specifically to meet those needs. It also stresses the need to include all stakeholders in this process including patients and local communities.
4.2. Learning Methods

The literature rightly promotes a strong emphasis on the specific clinical and technical knowledge and skills which maintain and enhance competence. For such skills there is a growing literature on the role of simulation (Freeth et al. 2009; Lathrop et al. 2007) and ‘Training the Trainer’ models (Doyle et al. 2008). The literature generally agrees that no one method of learning can be cited as more effective than another, and many authors propose mixed methodology or blended learning (Barr 2009; O’Brien et al. 2001).

However, much of the literature, regardless of the primary methodology, or the learning topic places a significant emphasis on reflection, and work based learning, often guided or supported by a more experienced colleague. Reflection is sometimes linked to clinical supervision (DoH 2008), but contemporary literature seems to favour a broader view of guided reflection, which can be individual or in groups, and/or linked to specific case-based issues in practice; there is a recognition that work-based learning is crucially important as it is viewed by the practitioners as highly relevant and can be instrumental in supporting team as well as individual practitioner development (Fletcher 2008).

The centrality of reflection has implications for the infrastructure needed to provide it, particularly guided reflection, and there is a substantial literature on the role of workplace mentors, preceptors, learning co-ordinators, practice education and practice development staff. Organisations need to invest and develop supervisors and managers and senior clinicians to develop skills in guidance and feedback, as well as appraisal as a learning tool, which are often cited, by allied health professions in particular, as very effective education activities (French and Dowds 2008). In addition, technical infrastructure is necessary to enable practitioners to easily access the internet and/or videoconferencing facilities to support professional networking (McGarry et al. 2009; White 2009).

Distance learning, often with a mix of paper-based and e-learning materials is also viewed favourably, particularly by practitioners in remote and rural practice; however over dependence on this methodology can be seen as a demotivating factor as learning
tends to encroach on private time (Gould, Drey et al.2007).

Contemporary literature, therefore, increasingly supports more informal interactive and interpersonal / interprofessional methods which are self-directed and seen as relevant to the practitioner in the context of their role or service (Siddons and Rouse 2006). Given that this review is focusing on the needs of key frontline staff, who need to develop skills in decision making and problem solving, accessing more experienced professional others with time and skill to provide guidance and feedback, and having access to peer support during practice seems worthy of further exploration, and may be more effective and cost efficient than more formal CPD methods. Gopee (2005) proposes that profession based and informal personal networks tend to play a key role in encouraging and supporting learning. Indeed many educational developments undertaken by NHS Education for Scotland have established and maintained networks of practitioners (and managers /educators) and this has been seen as a significant factor in sharing knowledge and expertise, building confidence and in providing a forum for professional discussion and reflection which is often not available during clinical practice (NES 2009d).

The literature also reflects some early discussions on protected or dedicated time, built in to clinical practice and how this might be implemented interprofessionally, to improve effectiveness but maintain cost efficiency (Sturrock and Lennie 2009; White 2005; NES 2009a).

Much of the policy context refers to the importance of working together in effective multiprofessional teams, and the profession-specific literature also stresses the need to learn and work interprofessionally, in a multiprofessional, and increasingly multi-agency context. Whilst the literature on interprofessional education (IPE) reports variable results, there is emerging evidence that IPE improves how professionals work together and the care they provide (Reeves et al, 2008).
4.3. Potential barriers to accessing and implementing learning from CPD

It is clear from the literature that a complex range and inter-relationship of factors are necessary for clinical practice to evolve, change and improve. Many of these factors have in themselves significant implications for the education and ongoing CPD of staff at all levels. No differences have been found across the professions in respect of what motivates practitioners to engage in CPD; it is for the most part intrinsically driven. But one of the significant factors in the literature was the attitude of the organisation, and particularly of managers, and whether they were seen as engaged with the process of CPD, demonstrated that they valued appraisal and CPD, and supported staff to implement change post education (Hughes 2005; Bahn 2007; Berridge et al 2007; King 2009; Drey et al 2009). This has implications for the CPD of clinical and senior managers (Gould et al. 2007), and is articulated well in The Senior Charge Nurse Review (SGHD 2008b).

Organisational culture emerges as a key theme in the literature, as both a facilitator and an inhibitor for using CPD as a vehicle for promoting change and improvement. It is front line staff who face the challenges of accountability in their face to face interventions with the public, and effective practitioners need the skills not just to really understand what will make a difference for each individual patient, but the skills and confidence to negotiate solutions within their team and beyond into the organisation. However the skills are only one element; perceptions of role, are often defined within role descriptions and job profiles, and these can be interpreted in a way which constrains practitioners from feeling able to meet patients needs on an individualized, personalised basis. Organisations need to promote a culture at all levels which encourage challenge and problem solving approaches.

5. Discussion

Current literature is very focused on the dilemma inherent in the aims of CPD:

- Is the main aim individual practitioner improvement or service improvement?
- and
- How can both of these be achieved within the current financial climate?

Bjork et al (2009) stress the need for managers to be able to justify the cost of education
and provide a rationale for moving to a more systems way of thinking. Lee et al (2009) suggest that staff turnover rates and patient safety can be significantly reduced by investing in infrastructure such as preceptors. The KSF, while offering opportunities to link personal and organisational aspirations through role, also has cost implications and may well challenge managers and education providers (Gould et al 2007), as employees now have opportunities to explicitly or implicitly select their own learning activities (Berings et al 2007). The literature suggests that CPD programs are more effective when they are constructed to encourage health professionals to take the initiative and direct their own learning, relevant to the clinical challenges they encounter. The literature also suggests that one of the answers may lie in team-based and/or shared CPD, both for cost efficiency reasons and if it is to effect service care delivery improvement. And while there are challenges in that, for many services there is a need to make that CPD available across other agencies as well. While individual professions have to some extent their preferred learning styles and methods the most effective appear to be the more interactive, and participative; certainly case based critical discussions/ workshops linked to some form of clinical supervision, and using guided reflection, often with the help of a more experienced other in a mentor/ facilitator role.

There is also a strong thread in the literature about the involvement of patients, and local communities in both needs assessment and CPD activity; examples are already evident in NES facilitated Mental Health work in Scotland, and there is a lot of evidence from specialist services across the world-substance abuse, diabetes, physical disability across a range of professions, nursing, midwifery, physio and occupational therapy in particular. Fleet et al (2008 ) present a useful selection of best practice from Europe and Canada.

The recent learning needs analysis in relation to long term conditions (NES 2009), highlights the expressed need from practitioners for skills in person-centred ways of working, coaching, teaching and motivational interviewing, and skills to help the practitioner empathise with the patient during the journey of care.
6. Conclusion

CPD to support effective practitioners is about much more than skills training and updating and instilling new knowledge:

- It is about developing practitioners and teams who can survive and prosper in a changing and demanding environment.
- It is about really listening to what patients want and what works for them as individuals.
- It is about learning to be an effective member of an effective team.
- It is about learning how to ask ‘why not?’ when a patient asks for something unusual.
- It is also about critical thinking and problem solving.

These principles are not solitary professional activities, and are best learned in the broadest context of the specific service and within a multiprofessional and or cross agency environment. A national approach to supporting level 5 and 6 NMAHP’s with shared evidence based outcomes would be preferable to a one size fits all national programme. This could then be customised, owned and driven at a local level.
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2. Introduction

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The review was informed by published studies and articles, web based information for example from Health Board and Higher Education websites, and survey data from Governments and relevant professional bodies. The scope of the review was to include clarification of these needs as perceived by both the practitioners and by their managers/employers, and to reflect current health and education policy, in the context of service change and existing and future role development, primarily though not exclusively in the United Kingdom.

A range of uniprofessional literature was accessed; however, it is not the purpose of the review to summarise each profession’s views or priorities, but to reflect the common
themes in relation to both learning content and methodology, and in respect of the factors which appear to facilitate or constrain the implementation of learning into clinical practice.

The review is presented under the following themes:

- The search methodology and review limitations
- Terminology
- Themes from the literature in relation to
  - Learning needs
  - Learning methods
  - Potential barriers to accessing and implementing the learning from CPD
- Discussion and conclusion

2. Methodology

2.1. Search Methods
A computerised search of publications between 1999 and 2009 was conducted using the NHS Scotland elibrary, to access CINAHL, Medline, the Cochrane databases and the Internet. This was followed by a literature search of relevant references in the studies included. The keywords used in the search included ‘effective’, ‘effective practice’, ‘continuing education’, ‘continuing professional development’, impact of continuing education/professional development programmes’, ‘evaluation of continuing education/professional development programmes’ and ‘effectiveness of continuing education/ professional development programmes’. Criteria for inclusion where that the main content was specific to continuing education, included a form of evaluation, and / or was specific to the effectiveness or impact of continuing education in healthcare professions. A total of 83 articles met the selection criteria and have been cited in the review.

Of particular relevance to this review were two systematic reviews from the Cochrane database (O’Brien et al. 2001; Reeves et al. 2008) and a Canadian literature review carried out in 2008 by Fleet et al., which discusses social accountability and identifies a range of good practice in interprofessional learning. Other key texts were by French
(2006), who conducted a survey of physiotherapists, Cusick et al. (2009), who described CPD for Occupational Therapists, and Henwood et al. (2004) who conducted a comparative study of radiographers attitudes to CPD in the UK and New Zealand. The study by Calnan and Rowe, (2008) was also significant in contributing to the discussion on social accountability.

2.2. Limitations
The literature on CPD reflects both unprofessional and multiprofessional studies. The available literature in terms of numbers of published articles does reflect a bias towards nursing, followed by physiotherapy, occupational therapy and radiography, but the themes across the professions were consistent. The overwhelming majority of studies are small in scale, and evaluation tends to be at an individual teaching/learning programme level, and based on the self assessment and perceptions of the practitioners undertaking them. There is a notable lack of involvement of other stakeholders both in relation to learning needs and their perceptions of change and /or improvement.

More recent literature (see for example Fleet 2008) describes multiprofessional larger scale programmes, often involving local communities and service users, but given the range of care contexts, and the diverse nature of the learning content it is difficult to generalise from their findings.

Furthermore the studies focus on those undertaking CPD; it is more difficult to access the views of those who do not actively engage in CPD, or who define CPD as a particularly narrow group of formal education activities (Bolton 2002; Marshall et al 2008; Henwood & Taket 2008).

3. Terminology
The terminology used within the literature is helpful to clarify understanding of both the effectiveness of CPD and what stakeholders understand by the term. Additionally, the effective practitioner is the working title of this initiative, and exploration of related terminology may assist in the agreement of the title.
3.1. Effectiveness of CPD

The Collins English Dictionary (2003) defines effective as:

1. Productive of, or capable of producing an effect
2. In effect, operative
3. Producing a striking impression; impressive
4. Actual rather than theoretical
5. Equipped and prepared for action
6. Efficient (from Collins Thesaurus)

The literature on the effectiveness of CPD reflects the challenges of these nuanced definitions, with most taking the perspective of the practitioners on the effectiveness of their learning in respect of new skills, improved competence and/or understanding of conditions. Interestingly, from a small sample of University websites offering programmes on Effective Practice the development of clinical knowledge and skill is a relatively small aspect, the focus being on other factors which impact on effective practice, such as, reflection, change management, clinical governance, clinical effectiveness and role theory (University of Bedfordshire 2009; University Campus Suffolk 2009). In addition there is some literature which explores effectiveness in terms of efficiency; this has been excluded for the purposes of this review, unless it referred specifically to CPD.

Whilst this review focuses on the needs of practitioners at Levels 5 and 6 of the Career Framework for Health, the literature about the content of CPD programmes across the healthcare professions reflects the need for learning and development in each of the four pillars of practice as defined within advance professional practice. These are: clinical practice, leadership and management, evidence in practice, learning teaching and supervision (SGHD 2008a). Working effectively in teams is also a common learning need (Fletcher 2008).

3.2. Continuing Professional Development

The literature includes some issues in relation to understanding of the purpose of CPD. Hughes (2005) notes that while there are many methods of CPD, policy makers and
professional organisations tend to focus on outcome and define it as:

‘...a process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to fulfil their potential...’ (cited in Hughes from DoH 1999).

The Chartered Society of Physiotherapists, (2005) also defines it as a process

‘...through which individuals undertake learning, through a broad range of activities that maintain, develop and enhance skills and knowledge in order to improve performance’.

while the Health Professions Council (HPC 2009) defines it as

‘a range of activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely effectively and legally within their evolving scope of practice.’

So while there is a consensus that it is a career-long range of activities; the rationale and outcomes carry varying emphases.

More recent literature, including health policy stresses the need to add public safety as an aim of CPD, and in its broader context to include a wider and more direct accountability to patients and the wider public. (Fleet et al. 2008; Fletcher 2008; SGHD 2007).

As will be discussed later, this concept of ‘social accountability’ is articulated in a wide range of learning needs identified across the professions, particularly in the need to find better ways of working in partnership with patients, and collaborating with a range of agencies beyond health and social care.

This adds to the challenge of aligning the needs of the individual practitioner with the needs of the employing organisation (Munro 2008). Both will have to find ways of engaging the wider public in the planning, delivery and evaluation of CPD if the aspirations of policy around partnership are to be realised, as is described for example in Better Together, the Scottish Government’s Patient Experience Programme, (SGHD 2008c) and in Midwifery 2020, and Modernising Nursing Careers, (DoH (E) 2006). If CPD is to be one of the vehicles to improve practice, and to make practitioners more effective, then all stakeholders must be involved in deciding prioritising the outcomes to
be improved, and the range of learning needs to be addressed.

4. Themes from the literature

The perceptions of CPD needs across professions is presented within this literature review under broad themes: these include: learning needs, learning methods, and potential barriers to accessing and implementing learning from CPD. Discussion of some relevant specific issues are included under each theme and an overall discussion is included in the next section.

4.1. Learning Needs

Perhaps it is not surprising that the profession specific literature has many common themes, and describes the same issues around:

- Maintaining and updating clinical skill and knowledge (Bolton 2002; Gill 2007; Doyle et al. 2008; French 2006; King 2009; Freeth et al. 2009; NES 2007; Ireland et al. 2007)


- Challenges around accessing and understanding the evidence base for effective practice given information overload at work and issues of access to on-line material (Bourne et al. 2007; Griscti & Jacono 2006; Schoo et al. 2008; Ireland et al. 2007)

- Managing change and surviving (DoH (E) 2006; DoH (E) 2008; NES 2007; Mann et al. 2009; Simpson 2009)

- Professional relationships within and across professions, teams, organisations and agencies (Fleet et al. 2008; Simpson 2009; Wilcock et al. 2009; Barr 2009; Robertson & Bandali 2008)

But there are also other common factors, not least of which is the crucial importance all place on their relationships with patients and clients (Fleet et al. 2008; NES 2009c; SGHD 2008c) and the new and different forms of accountability and trust professionals need to sustain at a time when this has to be earned and is not automatic, and when public confidence in the NHS and it’s workforce can sometimes be portrayed as being very low (Cainan and Rowe 2009).
A decade ago a study in Hong Kong identified a range of personal characteristics that contributed to effective practice (in nursing) (Zhang et al. 2001). The highest ranked in that study was interpersonal understanding; but commitment, information gathering, compassion, persuasiveness and critical thinking all ranked highly. Interpersonal understanding encompasses empathy, and was described as the ability to understand people’s ‘expressed and/or unexpressed thoughts, emotions and concerns’ (p470). The desire for support to develop skills in this area is expressed in all of the recent learning needs surveys, across the professions, while much of the contemporary literature reflects a focus on the acquisition of knowledge and skills, including emotional and interpersonal learning (e.g. Lacey 2009). Spinks (2009) uses the term emotional intelligence, and states that both front line practitioners and their leaders need to take forward the cultural change to ensure that patients receive high quality compassionate care. Calnan and Rowe, (2009) in their thought provoking research note that trust is still important for effective therapeutic relationships, and is earned via the experience of care, the quality of patient-practitioner interaction, and the compassion and empathy displayed (p102).

More detailed elements which practitioners believe they need in relation to CPD, also demonstrate consistency from the recent surveys carried out by governments professional organisations and the literature.

- Research/Evidence based practice (NES 2007; NES 2009a/b; Cusick and McCluskey 2000; Matter 2006)
- Clinical assessment, clinical decision making, and team working (SGHD 2006; French 2006; Bourne et al. 2007; Kenwood and Styles 2009)
- Audit / clinical effectiveness (Lawton et al. 2009; Wainwright and Canning 2008; Bramley 2006)
- Skills to support service redesign/workforce planning; conflict management, (NES 2009c; DoH(E) 2008)
- Advanced communication skills e.g. negotiation and influencing skills, partnership working, motivational interviewing (NES 2009c; Fleet et al. 2008)
- Leadership, management, caseload management; skills to support self-management (NES 2009c; Fleet et al. 2008; Lannon 2007; Porter et al. 2006)
• Health Improvement/Health Promotion Skills (SHHD 2006)
• Political Awareness (NES 2007)

In relation to those communication skills to aid partnership working, the learning needs analysis for long term conditions (NES 2009c) proposes that it may be difficult for practitioners to be effective as part of a multiprofessional (or multi-agency) team without these key skills. Chevannes (2002), in her study into meeting the needs of ethnic minorities also stresses the need for training to be embedded in both clinical and non-clinical environments, where patients and other service users and professionals interact together.

Calnan and Rowe (2008) emphasise the need for practitioners to learn how to influence both within and outwith their own teams, across professions and their managers at all levels, in order to function as effective teams and deliver effective care. Porter et al. (2006) emphasise the need for staff (at the equivalent of levels 5 and 6) to learn operational management skills, not just in preparation for more senior roles but staff at these levels are increasingly asked to take leadership responsibility for elements of care within the team, and also become involved in taking forward disciplinary and other management tasks, previously carried out by human resources staff.

In relation to clinical audit and clinical effectiveness, Lawton et al. 2009 identifies the need for practitioners to be equipped with the knowledge, skills and confidence to examine their work and improve care when necessary.

4.1.1. Training Needs Analyses (TNA)
The literature does have a consensus on the effectiveness and efficiency of using validated training needs analyses at a local level to establish the specific learning needs within a service and tailor the education specifically to meet those needs. Hicks and Thomas (2005) used a validated TNA instrument, to assess the needs of community sexual health workers; when the professional sub-samples were analysed separately the same generic training needs emerged. They proposed that using this systematically, would provide more cost effective education by meeting real need and
providing shared learning opportunities which in turn would promote better interprofessional and team working.

O’Hara et al (2007), similarly conducted a TNA amongst district nurses to identify their needs in relation to palliative care, and described the benefits of providing education tailored to local needs.

Gould et al. (2004) conducted a literature review of TNAs, Most of the accounts they examined were concerned with the training needs of nurses in more than one organisation and were classified as ‘macro-level’ training needs analyses. However, seven studies were concerned with a single, specific organisation (‘micro-level’ training needs analysis) which, despite their smaller scale demonstrated greater methodological rigour, were more likely to consider the perspective of stakeholders, generated findings which could positively influence the rest of the training cycle and showed the greatest potential for influencing service delivery and quality of patient care. Griscti and Jacono (2006) stress the importance of all stakeholders, including service users and the public being involved at this early assessment stage, if the TNA is to have any relevance to changes in practice and patient outcomes. In a study by Berridge et al (2007), on staff appraisal, it was noted that commissioning of training was insufficiently responsive to identified needs, and led to staff viewing appraisal as less than effective. It would be important therefore to ensure that a clear link between needs, learning and development and patient outcomes is established and maintained at local levels. Fleet et al. (2008) also emphasise that the CPD opportunities being made available to professionals should be informed by the views and needs of both providers and patients.

4.2. Learning Methods
CPD for practitioners rightly includes a wide range of teaching and learning methods, though the understanding of what constitutes CPD activity varies across and within professions (Bolton 2002), and there is a strong emphasis on the specific clinical and technical knowledge and skills which maintain and enhance competence. For such skills there is a growing literature on the role of simulation (Freeth et al. 2009; Lathrop et al. 2007) and ‘Training the Trainer’ models (Doyle et al. 2008). The literature generally agrees that no one method of learning can be cited as more effective than another, and
many authors propose mixed methodology or blended learning (Barr 2009; O'Brien et al. 2001). In their Cochrane systematic Review, O'Brien et al. (2001) concluded that interactive methods (they were looking at conferences and workshops) either alone or combined with other interventions were likely to be more effective than any solely didactic format.

4.2.1. Support and reflection

Much of the literature, regardless of the primary methodology, or the learning topic there is a significant emphasis on reflection, often guided or supported by a more experienced colleague. This is sometimes linked to clinical supervision, (DoH 2008) but contemporary literature seems to favour a broader view of guided reflection, which can be individual (Banning and Stafford 2008; Chapman et al 2009) or in groups (Yearly 2003;) and/or linked to specific case-based issues in practice; there is a recognition that work-based learning is important as it is viewed as highly relevant (Mathers et al.2007) and can be instrumental in supporting team as well as individual practitioner development (Fletcher 2008).

Cusick et al. (2009) promotes guided reflection within a conceptual framework of clinical reasoning within Occupational Therapy to help professional development make an impact on practice. Similarly French (2006) moves away from traditional models of clinical supervision, towards guided reflection and links it with peer review.

There is evidence to support reflection via the development of peer support groups such as networks and journal clubs, (Plastow et al 2006 ) and interprofessional networks around the care and treatment of particular conditions (Delisio 2009; Halcombe et al 2009).

Some of the literature sees reflection and mentoring as other than CPD; Griscti and Jacono ( 2006) cite them as ‘alternative measures to continuing education’ which are effective in the promotion of knowledge acquisition, ensuring public safety and continued competency, in a constantly changing care context.
The centrality of reflection has implications for the infrastructure needed to provide it, particularly guided reflection, and there is a substantial literature on the role of workplace mentors, preceptors, learning co-ordinators, practice education and practice development staff. Organisations need to invest and develop supervisors and managers and senior clinicians to develop skills in guidance and feedback, as well as appraisal as a learning tool, which are often cited, by allied health professions in particular, as very effective education activities (French and Dowds 2008). In addition, technical infrastructure is necessary to enable practitioners to easily access the internet and/or videoconferencing facilities to support professional networking (McGarry et al. 2009; White 2009).

King (2009) offers a useful framework of strategies to foster learning and therapist expertise - personal experience to develop skills and knowledge, the provision of supports and resources, and workplace opportunities, which together provide a comprehensive model to facilitate experiential, instructional and observational learning.

4.2.2. Distance Learning
Many practitioners favour distance learning, often with a mix of paper-based and e-learning materials (Marshall et al 2008). Practitioners in remote and rural areas, have particular need of distance learning and accessible on-line materials (Ireland et al. 2007; Southernwood 2008). Online tools or CD-ROMs are particularly useful as they can be ‘picked-up and put-down’ at convenient times (Gill 2007; White 2009; Marshall et al 2008; NES 2007). Southernwood (2008) in particular emphasises the efficiencies in both costs and time for community practitioners, indicating it can help maintain a work life balance. However other authors warn that distance and online learning tends to encroach on private time and can be seen as a de-motivator for involvement in CPD (Gould, Drey et al.2007).

The development of portfolios and eportfolios is cited as a useful in developing and assessing CPD activity, particularly skills based learning (Anderson et al 2009). However, despite the mandatory requirement to develop a portfolio in some professions, there still seems much ambivalence and confusion as to the nature and effectiveness both as a learning and an assessment tool (Joyce 2005; Bowers and Jinks 2004).
4.2.3. Work Based Learning

Mathers et al (2007) conducted an interprofessional multi-site European project in primary care using web-based and team focused education interventions. All members of each team were involved from the beginning in identifying learning needs and the authors proposed that this increased the probability that the agreed educational objectives in the team-learning plans were based on needs as well as wants. They cited evidence of the importance of learning taking place in the workplace since it is far more likely to be relevant and reinforced, leading to better practice. However they did not report if the learning outcomes of the programme, such as the agreed clinical and organisational protocols, were actually implemented in practice or indeed to what extent they may have resulted in improved patient care. They did note however, that skilled facilitation was an essential component in the implementation of the programme. Lawton et al. (2009) also describe using a problem based learning approach to develop audit skills, and noted that learning in the work setting enabled the practitioners to gain confidence.

4.2.4. Networking /Access to other professions/other teams/other services

As noted above, the literature generally agrees that no one method of learning can be cited as more effective than another. While distance and on-line learning can have advantages face-to-face contact with others, clinical and professional debate and discussion is generally seen as making an important contribution to CPD. Conferences and workshops generally evaluate well, though it is difficult to estimate the impact they have on practice (O’Brien et al. 2001). But increasingly the literature supports more informal interactive and interpersonal methods which are self-directed and seen as relevant to the practitioner in the context of their role or service (Siddons and Rouse 2006). Given that this review is focusing on the needs of key frontline staff, who need to develop skills in decision making and problem solving, accessing more experienced professional others with time and skill to provide guidance and feedback, and having access to peer support during practice seems worthy of further exploration, and may be more effective and cost efficient than more formal CPD methods. Gopee (2005) proposes that profession based and informal personal networks tend to play a key role in encouraging and supporting learning. Many educational developments undertaken by NHS Education for Scotland have established and maintained networks of practitioners
(and managers /educators) and this has been seen as a significant factor in sharing knowledge and expertise, building confidence and in providing a forum for professional discussion, and reflection which is often not available during clinical practice (NES 2009d). McGarry et al. (2009) describe the use of videoconferencing to build communities of professional practice, while Heath et al (2008) use it to promote interprofessional learning networks, as a way of building capacity to deal with mental health problems in rural communities.

Again these methods have cost implications; Fleet et al. 2008 reinforces the need for infrastructure including professional networks (and the associated time and technical expertise) to support interprofessional collaboration, and shared learning. The literature reflects some early discussions on protected or dedicated time, built in to clinical practice and how this might be implemented interprofessionally, to improve effectiveness but maintain cost efficiency (Sturrock and Lennie 2009; White 2005; NES 2009a).

4.2.5. Interprofessional and team-based learning

Much of the policy context refers to the importance of working together in effective multiprofessional teams, for example in Midwifery 2020, Modernising Nursing Careers, and Better Health Better Care. Profession specific literature stresses the importance of the multiprofessional context, both of care and of learning, and offers a range of reasons for an inclusive approach to CPD (Fletcher 2008; Barr 2009; Bjork 2009; Freeth et al 2009; Hicks and Thomas 2005; Milburn and Coyler 2008). The range of methods for interprofessional education (IPE) are much the same as for individual CPD.

Mann et al (2009) used Green and Kreuter’s model of factors which influence change, and cited high levels of self-reported changes in both clinical practice and interpersonal interactions 3 months after a series of interprofessional training sessions in cancer care. However Reeves et al.,(2008) in their systematic review of six studies on the Cochrane database, found in four of these some evidence that IPE improved some ways in how professionals worked together and the care they provided. It improved the working culture and patient satisfaction, and decreased errors in an emergency department; it improved the management of the care delivered to domestic violence victims; and improved the knowledge and skills of professionals providing care to mental health
patients. But two of those four studies also found that IPE had little to no effect on other areas. Two other studies found that IPE had little to no effect at all. However, the studies evaluated different types of IPE and were not of high quality, so the authors concluded it was difficult to be certain about the effect of IPE and to understand the key features of IPE to train health and social care professionals to work together effectively.

Fleet et al 2008 cite a 1996 pilot programme- a case based education programme on heart health for physicians, nurses, dieticians, pharmacists, social workers recreation professionals and health educators, which was evaluated as effective for promoting interprofessional working and collaboration. It especially noted the value of learning about the roles and contributions of other professionals.

4.3. Potential barriers to accessing and implementing learning from CPD

Furze and Pearcey noted in their 1999 literature review that continuing education provision (in nursing) was fragmented, inequitable and poorly funded, and that there was a lack of research into the impact on care. It would appear that much has changed over the intervening years. Recent surveys indicate that some nurses perceive an increase in their access to CPD, though the RCN (2009) survey notes that annual CPD in the NHS fell from 11 days in 2005 to 7 days in 2007, and has remained constant there in 2009.

Nevertheless, staff indicate that they believe they have the knowledge, skills, and competence to carry out their role (ICN 2008; RCN 2008; SGHD 2008; DoH (E) 2008). Research into the impact of CPD on patient care and care outcomes, however, remains sparse. There is little empirical evidence in the literature that CPD programmes for healthcare professionals enhance care delivered (Jordan 2000; Griscti and Jacono 2006; Fleet et al 2008). and Cusick et al. in 2009 advise the unwary to question the assumption that individual professional development can attain organisational goals.

To evaluate courses and demonstrate educational effectiveness solely in terms of learner satisfaction is not enough; to survive in the world of evidence-based care, educators must also demonstrate their contribution to clinical effectiveness (Jordan 2000).
What is clear from the literature is the complexity; the range and inter-relationship of factors that are necessary for practice to evolve, change and improve. Many of these factors have in themselves significant implications for the education and ongoing CPD of staff at all levels.

4.3.1. Motivation to engage in CPD

And while the literature focuses on those undertaking CPD, there is also concern about those who are apathetic to engaging with it at all. Ryan (2003) discusses factors which motivate healthcare professionals (in this study nurses, occupational therapists and physiotherapists) to engage in CPD activity. No differences were found between the professions; it was proposed that engagement is intrinsically driven, for increased professional knowledge, demonstrating professional competence, updating of existing qualifications and to raise the status of the profession. Bahn (2007) indicates that some nurses were motivated by a fear of being left behind by the higher educational of nurses now entering the profession, but also a perception that higher education did in fact contribute to enhanced patient care. But one of the significant factors in the literature was the attitude of the organisation, and particularly of managers, and whether they were seen as engaged with the process of CPD, demonstrated that they valued appraisal and CPD, and supported staff to implement change post education (Hughes 2005; Bahn 2007; Berridge et al 2007; King 2009; Drey et al 2009). This has implications for the CPD of clinical and senior managers (Gould et al. 2007), and is articulated well in The Senior Charge Nurse Review (SGHD 2008b).

4.3.2. Organisational Culture

Organisational culture emerges as a key theme in the literature, as both a facilitator and an inhibitor for using CPD as a vehicle for promoting change and improvement. Lloyd Jones (2005) systematic review and meta analysis of the barriers and facilitators to effective practice in specialist and advanced practitioner roles in acute hospital settings, describes some factors which may be significant and pertinent to staff at levels 5 and 6 of the career framework:

- their relationships with other staff groups; 5’s and 6s need to develop influencing skills to be effective within their teams, as well as to progress
- Practitioner confidence: practitioners who are going to engage in change need to
have confidence in their clinical and professional judgements

- Conflict and change management skills, to challenge the status quo and influence other significant and senior clinicians and managers.

This is not only about preparation for a more senior role, but about equipping front line staff with the skills they need to be active effective team members. It is front line staff who face the challenges of accountability in their face to face interventions with the public, and effective practitioners need the skills to really understand what will make a difference for each person, and the skills to negotiate within their team and beyond to make sure their patient gets as close to that as possible. However the skills are only one element; perceptions of role, are often defined within role descriptions and job profiles, and these can be interpreted in a way which constrains practitioners from feeling able to meet patients needs on an individualized, personalised basis. Lillas (2001) in his thesis on community development, comments that the concept of role in itself can be limiting, and might act as a straightjacket, and the restrictions that it sets may not be advantageous to the community you are trying to serve.

The relationship between practice development and professional development becomes more blurred when one takes a team-based and local approach to CPD. McCormack et al (2009) discuss the use of practice development strategies to facilitate sustainable change in services caring for older people in Ireland. The findings of the first year of the programme are offered and these findings demonstrate the ways in which practice development systematically uncovers the deeply embedded characteristics of practice cultures - characteristics that often inhibit effective person-centred practice to be realised. In an earlier study, McCormack and Ives (2006) demonstrate that the implementation of practice development strategies can enable the development of a supportive learning environment, where staff are empowered to use their existing knowledge and expertise to identify the need for change.
5. Discussion

The literature cites many seemingly well evaluated studies of what works in relation to satisfying professionals to meet their personal and professional development needs, meet regulatory requirements, help them find the answers to particular issues/questions within their field, and/or to motivate them or keep them satisfied with their role. Clearly there is much written about the range of topics and methods which practitioners on the front line should or could theoretically access, and a substantial list of what would appear to be priority learning areas for practitioners. However, not all practitioners will need all of these topics at the same time or in the same way. There is little definitive evidence from the literature to guide practitioners, their managers and those responsible for the commissioning education/workforce development activities on the efficacy of such CPD to make practitioners more effective or to even change their practice in a systematic managed way. Continuing education is intended to ensure healthcare practitioners’ knowledge is current, but it is difficult to determine if those who attend these courses are implementing what they have learnt (Griscti and Jacono 2006; O'Brien et al 2001).

Current literature is very focused on the dilemma inherent in the aims of CPD; is the main aim individual practitioner improvement or service improvement?, and how can both of these be achieved within the current financial climate (Munro 2008). Bjork et al (2009) stress the need for managers to be able to justify the cost of education and provide a rationale for moving to a more systems way of thinking. Lee et al (2009) suggest that staff turnover rates and patient safety can be significantly reduced by investing in infrastructure such as preceptors. The KSF, while offering opportunities to link personal and organisational aspirations through role, also has cost implications and may well challenge managers and education providers (Gould et al 2007), as employees now have opportunities to explicitly or implicitly select their own learning activities (Berings et al 2007). The literature suggests that CPD programs are more effective when they are constructed to encourage health professionals to take the initiative and direct their own learning, relevant to the clinical challenges they encounter.
The literature also suggests that one of the answers may lie in team-based and/or shared CPD, both for cost efficiency reasons and if it is to effect service care delivery improvement. And while there are challenges in that, for many services there is a need to make that CPD available across other agencies as well. While individual professions have to some extent their preferred learning styles and methods the most effective appear to be the more interactive, and participative; certainly case based critical discussions/ workshops linked to some form of clinical supervision, and using guided reflection, often with the help of a more experienced other in a mentor/ facilitator role.

The literature supports the importance of local involvement, local decision making and local needs assessment, and there are examples of how this can be done within national initiatives (Forsyth 2004). However the growth of mandatory training is seen as a constraining factor to teams being able to engage in development activity designed to meet local needs in the delivery of local service change/improvement.

Who should be involved? There is a strong thread in the literature about the involvement of patients, and local communities in both needs assessment and CPD activity; examples are already evident in NES facilitated Mental Health work in Scotland, and there is a lot of evidence from specialist services across the world-substance abuse, diabetes, physical disability across a range of professions, nursing, midwifery, physio and occupational therapy in particular. Fleet et al (2008) present a useful selection of best practice from Europe and Canada.

Calnan and Rowe (2008) conducted a study to look at the role of trust in the delivery of contemporary care; they examined the factors that affect trust between front line practitioners and their patients, and between clinicians within teams and with their managers. They noted that trust remains important for effective therapeutic and professional relationships, but had to be earned. The changing care context, with more partnership working and shared care, and a greater interdependence among professionals in both health and social care, affected how that trust was earned and lost. They concluded that trust was earned via the patient's (and families') experience of care, through the quality of the practitioner patient interaction, and the compassion and empathy displayed. In effect trust is a quality indicator. Viewed from this perspective the
development of therapeutic relationships and the skills in managing and maintaining these is crucial to effective practice.

The recent learning needs analysis in relation to long term conditions (NES 2009), highlights the expressed need from practitioners for skills in person-centred ways of working, coaching, teaching and motivational interviewing, and skills to help the practitioner empathise with the patient during the journey of care. Equally the framework for Community Nurses (SGHD 2006), the survey of Practice nurses, and the AHP survey (NES 2007) identify the need for a similar range of skills.

6. Conclusion

CPD to support effective practitioners is about much more than skills training and updating and instilling new knowledge; it is about developing practitioners and teams who can survive and prosper in a changing and demanding environment. It is about really listening to what patients want and what works for them as individuals. It is about learning to be an effective member of an effective team. It is about learning how to ask ‘why not?’ when a patient asks for something unusual.

It is also about critical thinking and problem solving, but these are not solitary professional activities, and are best learned in the broadest context of the specific service within a multiprofessional and or cross agency environment. rather than the constraining context of the role. A national approach to supporting level 5 and 6 NMAHP’s with shared evidence based outcomes would be preferable to a one size fits all national programme. This could then be customised, owned and driven at a local level.

Lillas (2001) suggests that a human community is a ‘network of purposeful conversations about issues that concern them’ and sees effective practitioners as committed systemic learners, philosophers and facilitators with an outgoing (i.e. not egocentric) agenda. The focus for practitioners needs to be on values and principles as that is what is shared within the community, between the public and the practitioners, particularly frontline practitioners. Values need to be seen as a defining resource that articulates the
community’s deepest concerns.

This very much reflects the aspirations of health practitioners and health policymakers, who see care as being embedded in communities.
Appendix 1

Department of Health (England) 2008 What matters to staff in the NHS: research study conducted for Department of Health

Ten Factors that Matter to Staff:

Grouped into four themes –

The resources to deliver quality care for patients
I’ve got the knowledge, skills and equipment to do a good job
I feel fairly treated with pay, benefits and staff facilities.

The support I need to do a good job
I feel trusted, listened to and valued at work
My manager (or supervisor) supports me when I need it
Senior managers are involved with our work

A worthwhile job with the chance to develop
I’ve got a worthwhile job that makes a difference to patients
I help provide high quality patient care
I have the opportunity to develop my potential
I understand my role and where it fits in

The opportunity to improve the way we work
I am able to improve the way we work in my team

This research project demonstrates links between emotional motivators for staff and indicators of better services.

The full ‘What Matters’ report can be found on Ipsos MORI’s website at: http://www.ipsos-mori.com/content/research-archive/what-matters-to-staff-in-the-nhs-ashx
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